FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037267

Facility Name: Country Club Terrace

Address: 7800 West 183d Street (Number) Country Club Hills (City) 60478 (Zip Code)

County: Cook

Telephone Number: (708) 798-6616 **Fax #** (708) 798-0031

IDPA ID Number: 36-2171735

Date of Initial License for Current Owners: 8/15/91

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: George E. Miller **Telephone Number:** (708) 342-5352

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/03 to 6/30/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Wayne Kottmeyer

(Title) Executive Director

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/1/03 Ending: 6/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 16

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	16	Intermediate (ICF)	16	5,840	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	5,728			5,728	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,728			5,728	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.08%

D. How many bed-hold days during this year were paid by Public Aid? (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES [ ] NO [X]

I. On what date did you start providing long term care at this location? Date started 3/11/91

J. Was the facility purchased or leased after January 1, 1978? YES [X] Date 9/12/91 NO [ ]

K. Was the facility certified for Medicare during the reporting year? YES [ ] NO [X] If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 12/31 Fiscal Year: 6/30

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Country Club Terrace # 0037267 **Report Period Beginning:** 7/1/03 **Ending:** 6/30/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	39,657		960	40,617		40,617	24	40,641			1
2	Food Purchase		26,413		26,413		26,413	980	27,393			2
3	Housekeeping		13,109	14,400	27,509		27,509		27,509			3
4	Laundry		2,203		2,203		2,203		2,203			4
5	Heat and Other Utilities			10,652	10,652		10,652	1,412	12,064			5
6	Maintenance			5,571	5,571		5,571	20,285	25,856			6
7	Other (specify):*											7
8	**TOTAL General Services**	39,657	41,725	31,583	112,965		112,965	22,701	135,666			8
	B. Health Care and Programs											
9	Medical Director		2,072	6,000	8,072		8,072	2,827	10,899			9
10	Nursing and Medical Records	240,893	7,592	198	248,683		248,683	10,163	258,846			10
10a	Therapy											10a
11	Activities		1,984		1,984		1,984	33	2,017			11
12	Social Services	30,082			30,082		30,082	5,022	35,104			12
13	Nurse Aide Training							2,894	2,894			13
14	Program Transportation		5,103		5,103		5,103	3,682	8,785			14
15	Other (specify):* Dental			935	935		935	23,808	24,743			15
16	**TOTAL Health Care and Programs**	270,975	16,751	7,133	294,859		294,859	48,429	343,288			16
	C. General Administration											
17	Administrative	33,970			33,970		33,970	10,524	44,494			17
18	Directors Fees											18
19	Professional Services							11,452	11,452			19
20	Dues, Fees, Subscriptions & Promotions			100	100		100	1,530	1,630			20
21	Clerical & General Office Expenses		765	5,232	5,997		5,997	22,772	28,769			21
22	Employee Benefits & Payroll Taxes							93,747	93,747			22
23	Inservice Training & Education											23
24	Travel and Seminar			890	890		890	326	1,216			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice							4,357	4,357			26
27	Other (specify):*			2,831	2,831		2,831	773	3,604			27
28	**TOTAL General Administration**	33,970	765	9,053	43,788		43,788	145,481	189,269			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	344,602	59,241	47,769	451,612		451,612	216,611	668,223			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Country Club Terrace #0037267 Report Period Beginning: 7/1/03 Ending: 6/30/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			3,140	3,140		3,140	2,349	5,489			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			74	74		74	4,096	4,170			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			59,160	59,160		59,160	7,481	66,641			34
35	Rent-Equipment & Vehicles			516	516		516	877	1,393			35
36	Other (specify):*			954	954		954	623	1,577			36
37	**TOTAL Ownership**			63,844	63,844		63,844	15,426	79,270			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			939	939		939		939			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,257	49,257		49,257		49,257			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			50,196	50,196		50,196		50,196			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	344,602	59,241	161,809	565,652		565,652	232,037	797,689			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/1/03 Ending: 6/30/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	2,716			16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 2,716		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 2,716		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Country Club Terrace

ID# 0037267

Report Period Beginning: 7/1/03

Ending: 6/30/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Country Club Terrace # 0037267 **Report Period Beginning:** 7/1/03 **Ending:** 6/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Country Club Terrace** **#** **0037267** **Report Period Beginning:** **7/1/03** **Ending:** **6/30/04**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	0	0	0	0	0	0	0	0	0	0	0	45

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/1/03 Ending: 6/30/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Not Applicable				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$	Not Applicable		$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/1/03 Ending: 6/30/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Not Applicable								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/1/03 Ending: 6/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: St. Coletta's of Illinois
Street Address: 18350 Crossing Drive
City / State / Zip Code: Tinley Park, IL 60477
Phone Number: ((708)342-5200
Fax Number: ((708)342-2579

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Coffee & Supplies	Weighted Salaries	7,632,535	7	$ 2,529	$	72,943	$ 24	1
2	3	Housekeeping Consult #200	Weighted Salaries	7,632,535	7	88,705		72,943	848	2
3	3	Housekeeping Supplies #200	Weighted Salaries	7,632,535	7	13,801		72,943	132	3
4	5	Electric, Heat, Other #100	Contact Hours	5,480	7	373		384	26	4
5	5	Electric, Heat, Other #200	Weighted Salaries	7,632,535	7	144,993		72,943	1,386	5
6	6	Maintenance Staff #300	Contact Hours	13,276	7	207,979	207,979	929	14,554	6
7	6	Maintenance Consultants	Weighted Client Hours	9,020,917	7	11,190		474,913	589	7
8	6	Maintenance Supplies #300	Weighted Client Hours	9,020,917	7	4,661		474,913	245	8
9	6	Maintenance Services #200	Weighted Salaries	7,632,535	7	17,162		72,943	164	9
10	6	Maintenance Services #300	Weighted Client Hours	9,020,917	7	1,497		474,913	79	10
11	6	Maintenance Services #300	Direct	1	1	4,428		1	4,428	11
12	6	Maintenance Services #200	Weighted Salaries	7,632,535	7	17,813		72,943	170	12
13	6	Carpet Cleaning Fees #600	Contact Hours	20,236	5	6,630		172	56	13
14	9	Medical Dir Consultant #501	Client Hours	1,810,962	7	28,500		140,160	2,206	14
15	9	Pharmacist Consultant #501	Client Hours	1,810,962	7	3,600		140,160	279	15
16	9	Medical Supplies #501	Contact Hours	11,696	6	6,763		500	289	16
17	9	Medical Supplies #600	Contact Hours	20,236	4	6,246		172	53	17
18	10	Nursing Staff #501	Contact Hours	11,696	5	237,731	237,731	500	10,163	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 804,601	$ 445,710		$ 35,691	25

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/1/03 Ending: 6/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: St. Coletta's of Illinois
Street Address: 18350 Crossing Drive
City / State / Zip Code: Tinley Park IL 60477
Phone Number: ((708)342-5200
Fax Number: ((708)342-2579

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	11	Behavior Prog Supplies #108	Contact Hours	9,356	6	$ 73	$	1,052	$ 8	1
2	11	Atrium Supplies #200	Weighted Salaries	7,632,535	7	2,636		72,943	25	2
3	12	Ministry Staff #104	Contact Hours	1,912	7	28,976	28,976	134	2,031	3
4	12	Residential Staff #600	Contact Hours	20,236	4	349,817	349,817	173	2,991	4
5	13	Staff Training Salary #107	Contact Hours	518	7	13,625	13,625	36	947	5
6	13	Staff Training Supplies #107	Contact Hours	518	7	1,870		36	130	6
7	13	Consultants/Training #107	Contact Hours	518	7	26,145		36	1,817	7
8	14	Vehicle Upkeep Salary #325	Mileage	620,296	7	30,273	30,273	19,740	963	8
9	14	Vehicle Gas & Maint #325	Mileage	620,296	7	39,123		19,740	1,245	9
10	14	Vehicle Gas #100	Contact Hours	5,480	7	1,763		384	124	10
11	14	Vehicle Gas #300	Contact Hours	13,276	7	5,013		929	351	11
12	14	Vehicle Insurance #100	Contact Hours	5,480	7	1,520		384	107	12
13	14	Vehicle Insurance #300	Contact Hours	13,276	7	12,160		929	851	13
14	14	Staff Transportation #100	Contact Hours	5,480	7	52		384	4	14
15	14	Staff Transportation #102	Contact Hours	6,358	7	69		445	5	15
16	14	Staff Transportation #103	Contact Hours	5,027	7	79		352	6	16
17	14	Staff Transportation #300	Contact Hours	13,276	7	151		929	11	17
18	14	Staff Transportation #501	Contact Hours	11,696	6	260		500	11	18
19	14	Staff Transportation #600	Contact Hours	20,236	7	515		173	4	19
20	15	Psychological Staff #108	Contact Hours	9,356	5	175,345	175,345	1,052	19,716	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 689,465	$ 598,036		$ 31,347	25

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/1/03 Ending: 6/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: St. Coletta's of Illinois
Street Address: 18350 Crossing Drive
City / State / Zip Code: Tinley Park, IL 60477
Phone Number: ((708)342-5200
Fax Number: ((708)342-2579

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	15	Psychiatrist Consult. #108	DD Clients	1,444,824	3	$ 42,179	$	140,160	$ 4,092	1
2	17	Executive Director #100	DD Clients	2,128	7	150,304		149	10,524	2
3	19	Legal Fees & Consult. #100	Contact Hours	5,480	7	134,003		384	9,390	3
4	19	Legal Fees & Consult. #103	Contact Hours	5,027	7	14,297		352	1,001	4
5	19	Audit Fees #102	Weighted Client Hours	1,928,960	7	12,900		140,160	937	5
6	19	Computer Consult. #102	Contact Hours	6,358	7	1,771		445	124	6
7	20	Subscriptions #100	Contact Hours	5,480	7	577		384	40	7
8	20	Subscriptions #103	Contact Hours	5,027	7	320		352	22	8
9	20	Subscriptions #108	Contact Hours	9,356	5	267		1,052	30	9
10	20	Professional Member. #100	Contact Hours	5,480	7	3,220		384	226	10
11	20	Printing #100	Contact Hours	5,480	7	1,082		384	76	11
12	20	Postage & Shipping #105	Salaries	3,601,301	7	13,218		72,943	268	12
13	20	Permits & Fees #105	Salaries	3,601,301	7	220		72,943	4	13
14	20	Permits & Fees #200	Weighted Salaries	7,632,535	7	450		72,943	4	14
15	20	Advertising #103	Contact Hours	5,027	7	10,415		352	729	15
16	20	Illinois State Police #103	Contact Hours	5,027	7	1,871		352	131	16
17	21	Executive Staff #100	Contact Hours	5,480	7	45,727	45,727	384	3,204	17
18	21	Finance Staff #102	Contact Hours	6,358	7	142,365	142,365	445	9,964	18
19	21	Human Res. Staff #103	Contact Hours	5,027	7	90,952	90,952	352	6,369	19
20	21	Office Supplies #100	Contact Hours	5,480	7	1,322		384	93	20
21	21	Office Supplies #102	Contact Hours	6,358	7	7,381		445	517	21
22	21	Office Supplies #103	Contact Hours	5,027	7	2,016		352	141	22
23										23
24										24
25	TOTALS					$ 676,857	$ 279,044		$ 47,886	25

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/1/03 Ending: 6/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: St. Coletta's of Illinois
Street Address: 18350 Crossing Drive
City / State / Zip Code: Tinley Park, IL 60477
Phone Number: ((708)342-5200
Fax Number: ((708)342-2579

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Office Supplies #104	Contact Hours	1,912	7	$ 348	$	134	$ 24	1
2	21	Office Supplies #105	Salaries	3,601,301	7	8,908		72,943	180	2
3	21	Office Supplies #107	Contact Hours	518	7	75		36	5	3
4	21	Office Supplies #108	Contact Hours	9,356	7	208		1,052	23	4
5	21	Office Supplies #300	Contact Hours	13,276	7	156		929	11	5
6	21	Office Supplies #501	Contact Hours	11,696	7	1,096		500	47	6
7	21	Office Supplies #600	Contact Hours	20,236	7	300		173	3	7
8	21	Telephone/Cell #100	Contact Hours	5,480	7	4,203		384	295	8
9	21	Telephone #103	Contact Hours	5,027	7	782		352	55	9
10	21	Telephone #200	Overhead Salaies	1,652,320	7	32,046		72,943	1,415	10
11	21	Cell Phone #300	Contact Hours	13,276	7	4,624		929	324	11
12	21	Cell Phone #501	Contact Hours	11,696	7	787		500	34	12
13	21	Cell Phone #600	Contact Hours	20,236	5	8,010		173	68	13
14	22	Sisters FICA #104	Contact Hours	1,912	7	2,426		134	170	14
15	22	Christmas Gifts #105	Salaries	8,346,560	7	6,000		404,853	291	15
16	22	Employee Benefits #120	Salaries	8,346,560	7	1,923,209		404,853	93,286	16
17	24	Conventions & Meet. #100	Contact Hours	5,480	7	801		384	56	17
18	24	Conventions & Meet. #102	Contact Hours	6,358	7	337		445	24	18
19	24	Conventions & Meet. #103	Contact Hours	5,027	7	246		352	17	19
20	24	Conventions & Meet. #107	Contact Hours	518	7	1,509		36	105	20
21	24	Conventions & Meet. #108	Contact Hours	9,356	5	1,099		1,052	124	21
22	26	Property & Liab. Ins. #102	Salaries	8,346,560	7	88,704		404,853	4,303	22
23										23
24										24
25	TOTALS					$ 2,085,874	$		$ 100,860	25

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/1/03 Ending: 6/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: St. Coletta's of Illinois
Street Address: 18350 Crossing Drive
City / State / Zip Code: Tinley Park, IL 60477
Phone Number: ((708)342-5200
Fax Number: ((708)342-2579

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	26	Flood Insurance #200	Weighted Salaies	7,632,535	7	$ 5,667	$	72,943	$ 54	1
2	27	Board Related Expense #100	Contact Hours	5,480	7	2,941		384	206	2
3	27	Corporation Meeting #100	Contact Hours	5,480	7	798		384	56	3
4	27	Bank Fees #102	Contact Hours	6,358	7	1,476		445	103	4
5	27	Late Fees #102	Contact Hours	6,358	7	401		445	28	5
6	27	Memorials #104	Contact Hours	1,912	7	325		134	23	6
7	27	Start-up Expenses #200	Weighted Salaries	7,632,535	7	14,026		72,943	134	7
8	27	Use of Restrict. Funds #600	Contact Hours	20,236	7	638		173	5	8
9	27	Misc. Expense #100	Contact Hours	5,480	7	2,354		384	165	9
10	27	Misc. Expense #102	Contact Hours	6,358	7	560		445	39	10
11	27	Misc. Expense #103	Contact Hours	5,027	7	13		352	1	11
12	27	Misc. Expense #200	Weighted Salaries	7,632,535	7	702		72,943	7	12
13	27	Misc. Expense #600	Contact Hours	20,236	4	755		173	6	13
14	30	Depreciation-Auto #102	Overhead Salaries	1,652,320	7	18,749		72,943	828	14
15	30	Depreciation-Other #102	Client Hrs/Dir. Salary	9,020,917	7	28,893		474,913	1,521	15
16	32	SCIF Interest #100	Direct Revenue	13,535,347	7	65,215		819,731	3,950	16
17	32	Installment Interest #102	Overhead Salaries	1,652,320	7	3,307		72,943	146	17
18	34	Rental Expense #100	Contact Hours	5,480	7	9,280		384	650	18
19	34	Rental Expense #200	Weighted Salaries	7,632,535	7	373,032		72,943	3,565	19
20	34	Rental Office #200	Overhead Salaries	1,652,320	7	39,684		72,943	1,752	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 568,816	$		$ 13,239	25

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/1/03 Ending: 6/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: St. Coletta's
Street Address: 18350 Crossing Drive
City / State / Zip Code: Tinley Park, IL 60477
Phone Number: ((708)342-5200
Fax Number: ((708)342-2579

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	34	Rental Expense #300	Client Hr./Dir. Salary	9,020,917	7	$ 28,752	$	474,913	$ 1,514	1
2	35	Copier Lease #105	Salaries	3,601,301	7	42,363		72,943	858	2
3	35	Floor Covering Rental #200	Weighted Salaries	7,632,535	7	2,021		72,943	19	3
4	36	Equip. Under $500 #100	Client Hr./Dir. Salary	9,020,917	7	11,687		474,913	615	4
5	36	Equip. Under $500 #200	Weighted Salaries	7,632,535	7	811		72,943	8	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 85,634	$		$ 3,014	25

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/1/03 Ending: 6/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1				Not Applicable			$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6				Not Applicable								6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10				Not Applicable								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/1/03 Ending: 6/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1999	8
	2000	9
	2001	10
	2002	11
	2003	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Country Club Terrace COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037267

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/1/03 Ending: 6/30/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,200 B. General Construction Type: Exterior Aluminum Frame Masonry Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Not Applicable

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/1/03 Ending: 6/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Refer to Schedule VIII										9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/1/03 Ending: 6/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/1/03 Ending: 6/30/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ Refer to Schedule VIII	$	$	$		$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$	$	$	$		$	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Dodge Maxivan 2000	2000	$ 22,831	$ 2,854	$ 2,854	$	4	$ 22,831	76
77										77
78										78
79										79
80	TOTALS			$ 22,831	$ 2,854	$ 2,854	$		$ 22,831	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 22,831	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 2,854	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 2,854	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 22,831	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: St. Coletta's of Illinois Foundation

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1991	16		$ 59,160	1	20	3
4	Additions							4
5								5
6								6
7	TOTAL		16		$ 59,160 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 7/1/03
Ending 6/30/04

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	6/30/2005	$ 59,160
13.	6/30/2006	$ 59,160
14.	6/30/2007	$ 59,160

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Not Applicable		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/1/03 Ending: 6/30/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 80

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies			28		28
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)		84		84
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$ 112	$	$ 112
10	SUM OF line 9, col. 1 and 2	(e)	$ 112			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	1

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/1/03 Ending: 6/30/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$ Not Applicable		$	$		$ #VALUE!	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$ #VALUE!	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Country Club Terrace # 0037267 **Report Period Beginning:** 7/1/03 **Ending:** 6/30/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 440,879	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		164,855	6
7	Other Prepaid Expenses		91,765	7
8	Accounts Receivable (owners or related parties)		1,197,258	8
9	Other(specify): **Due from SCIF**		10,669	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$ 1,905,426	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost		79,108	15
16	Equipment, at Historical Cost		1,509,491	16
17	Accumulated Depreciation (book methods)		(1,319,056)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): **Invenstments & Deposits**		29,215	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 298,758	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$ 2,204,184	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 126,175	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		67,520	28
29	Short-Term Notes Payable		1,243,071	29
30	Accrued Salaries Payable		497,333	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	**Accrued Vacation**		52,995	36
37	**P/R Taxes & Benefits Payable**		39,394	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$ 2,026,488	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		77,921	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	**Deferred Revenue**		129,454	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 207,375	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$ 2,233,863	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 314,823	$ (28,509)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 314,823	$ 2,205,354	48

***(See instructions.)**

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/1/03 Ending: 6/30/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 275,170	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 275,170	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	39,653	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 39,653	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 314,823	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/1/03 Ending: 6/30/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 830,867	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 830,867	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education	5,225	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 5,225	23
	D. Non-Operating Revenue		
24	Contributions	1,250	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,250	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 837,342	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	135,666	31
32	Health Care	343,288	32
33	General Administration	189,269	33
	B. Capital Expense		
34	Ownership	79,270	34
	C. Ancillary Expense		
35	Special Cost Centers	939	35
36	Provider Participation Fee	49,257	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 797,689	40
41	**Income before Income Taxes (line 30 minus line 40)****	39,653	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 39,653	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/1/03 Ending: 6/30/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses		19	434	22.84	3
4	Licensed Practical Nurses		728	13,315	18.29	4
5	Nurse Aides & Orderlies		22,515	227,145	10.09	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook		2,374	22,872	9.63	14
15	Cook Helpers/Assistants		1,797	16,784	9.34	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator		1,202	33,970	28.26	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)		1,494	30,082	20.14	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)		30,129	$ 344,602 *	$ 11.44	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 960	Ln 1 Col 3	35
36	Medical Director		6,000	Ln 9 Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant		198	Ln 10 Col 3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Dental		935	Ln 15 Col 3	46
47	Outside Housekeeping		14,400	Ln 3 Col 3	47
48					48
49	TOTAL (lines 35 - 48)		$ 22,493		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/1/03 Ending: 6/30/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Patricia O'Brien	Administrator	0	$ 33,970
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 33,970

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 16,615
Unemployment Compensation Insurance	5,377
FICA Taxes	32,695
Employee Health Insurance	18,519
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	750
Life & LTD Insurance	3,118
Dental Insurance	2,477
Payroll Practice Plan	13,735
403b Administration	170
Other	291
TOTAL (agree to Schedule V, line 22, col.8)	$ 93,747

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	729
Health Care Worker Background Check	131
(Indicate # of checks performed)	
Permits & Fees	8
Subscriptions	92
Professional Memberships	226
Printing	76
Postage & Shipping	268
Other	100
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,630

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	326
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 326

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Country Club Terrace # 0037267 Report Period Beginning: 7/1/03 Ending: 6/30/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Country Club Terrace # 0037267 **Report Period Beginning:** 7/1/03 **Ending:** 6/30/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **49,257**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **N/A** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **0** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Mulcahy, Pauritsch, Salvador & Co.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Field work in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.